No. 80-756

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In the Supreme Court of the United States

OCTOBER TERM, 1980

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, AND ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, PETITIONERS

v.

GRAY PANTHERS

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

REPLY BRIEF FOR THE PETITIONERS

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1. The linchpin of respondent's argument is its repeated assertion (Resp. Br. 26, 42-46) that the term "available" income in 42 U.S.C. 1396a(a)(17)(B) only includes the income of an applicant's spouse if it is actually *contributed* to the applicant. The problem with this contention is that the term used in the statute is "available" and not "contributed." Moreover, the Secretary is expressly authorized by statute to define that term, and his regulations defining the term "available" income have never been construed by the

agency to exclude the income of an applicant's spouse simply because the spouse refused to contribute the income to the applicant but instead saved it or spent it on other goods and services.[1]

Section 1902(a)(17)(D) of the Act, 42 U.S.C. 1396a(a)(17)(D), clearly provides that (unless proscribed by the Secretary) participating states may consider the income of an applicant's spouse to be "available" to the applicant for the purposes of "determining eligibility for and the extent of medical assistance" (42 U.S.C. 1396a(a)(17)) to which the applicant is entitled under the Medicaid program. Yet respondent argues (Resp. Br. 17, 19, 39-40, 41-42, 44 n.11, 50, 60-70, 79) that this provision was intended only to allow participating states to enforce generally applicable civil or criminal relative responsibility statutes against the

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[1]Because the Secretary has never interpreted his regulations to prohibit consideration of the available income of a Medicaid applicant's spouse, whether or not actually "contributed," he has, as respondent concedes, "never moved to stop states from deeming" (Resp. Br. 48 n.14; see also *id.* at 2-3, 46-53, 56). But this merely indicates the agency's consistent, rather than its "schizophrenic" approach (*id.* at 48 n.14). Under this Court's precedents, substantial deference should be given to this consistent agency construction of its statute. See, *e.g.*, *New York State Department of Social Services* v. *Dublino*, 413 U.S. 405, 421 (1973); *Red Lion Broadcasting Co.* v. *FCC*, 395 U.S. 367, 381 & n.9 (1969); cf. *Udall* v. *Tallman*, 380 U.S. 1, 4 (1965).

Respondent also repeatedly quotes from the preamble to the regulations issued by the Secretary on December 15, 1980, in an effort to bolster its position. The preamble, however, contains the following passage (45 Fed. Reg. 82255):

> Should the Supreme Court grant review in *Gray Panthers*, it may be necessary to revise these regulations after the Supreme Court's decision on the merits. These regulations are based on the Court of Appeals' decision in *Gray Panthers*. That decision rejected the Department's legal analysis of the statute and ordered the Department to promulgate new deeming regulations specifying the circumstances under which and the extent to which deeming between spouses would be permitted based solely on the Department's analysis of the factors [the court] thought relevant.

spouses of Medicaid applicants or recipients. The language of the provision cannot bear that construction. Section 1902(a)(17) of the Act generally establishes guidelines for making initial Medicaid eligibility determinations. In making such determinations, the states must ignore "the financial responsibility of any individual for any [Medicaid] applicant or recipient * * * *unless such applicant or recipient is such individual's spouse* * * *" (42 U.S.C. 1396a(a)(17)(D)). Respondent makes no attempt to explain how its interpretation of clause (D) fits with the language and obvious purpose of Section 1902(a)(17). A state does not "tak[e] into account" the financial responsibility of a Medicaid applicant's spouse in "determining eligibility for and the extent of medical assistance" by *ignoring* the spouse's income in making those determinations and then filing a lawsuit against the applicant's spouse pursuant to a general support statute (assuming, of course, that the state even has such a statute).

Nor does respondent cite anything in the legislative history sufficient to support a reading of this provision so plainly at variance with its language.[2] Instead, respondent

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[2]Senator Hart's comment that the Medicaid Act would prohibit "many of the sad practices such as relative responsibility tests which have plagued Kerr-Mills programs in the past" (111 Cong. Rec. 15813 (1965)) does not address the question. As we noted in our opening brief (at 18-19 & n.10) the Act eliminated the "sad practices" by prohibiting consideration of the income of all relatives, except spouses and (in certain instances) parents. Similarly, Senator Ribicoff's statement "that contributions may be required only from spouses * * *" (111 Cong. Rec. 15804 (1965)) plainly supports the Secretary's reading of the statute and hardly suggests that the contributions could only be required by filing thousands of independent lawsuits. See *Brown* v. *Stanton*, 617 F. 2d 1224, 1234 (7th Cir. 1980) (Pell, J., dissenting), petition for cert. pending, No. 79-1690. Similarly, Senator McNamara's description of the bill, considered in context, does not support respondent's assertion (Resp. Br. 63) "that the purpose [of clause (D)] was to

observes (Resp. Br. 64) that "[t]here is no indication in the legislative history that Congress ever contemplated that clause (D) would expand the impact and effect of relative responsibility laws." Since Congress' primary concern was to establish guidelines "for determining eligibility for and the extent of medical assistance" (42 U.S.C. 1396a(a)(17)) under the Medicaid program, that is not surprising. Like the other parts of Section 1902(a)(17), clause (D) establishes guidelines for determining eligibility and the amount of assistance under the Medicaid program and, contrary to respondent's assertion, is not exclusively related to state enforcement of generally applicable support laws.

Respondent asserts (Resp. Br. 68-70) that Section 1902(a)(25) of the Act, 42 U.S.C. 1396a(a)(25), somehow supports its construction of Section 1902(a)(17)(D). Under Section 1902(a)(25) of the Act, a state Medicaid plan must

> provide (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the *legal liability of third parties to pay for care and services* (available under the plan) *arising out of injury, disease, or disability,* (B) that where the state or local agency knows that a third party has such a legal liability such agency *will treat such legal liability as a resource of the individual* * * * *for purposes of*

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avoid the use of relative responsibility laws" or that clause (D) had anything to do with state enforcement of such generally applicable civil or criminal laws:

> First. The family responsibilty [*sic*] provisions which imposed hardships on the children and grandchildren of elderly applicants for aid—and which often served to deter otherwise qualified individuals from seeking help. The new bill would limit the application of the family responsibility provision to the spouse, if any, of the applicant.

111 Cong. Rec. 15876 (1965).

> *[Section 1902(a)] (17)(B),* and (C) that in any case where such a legal liability is found to exist * * * the State or local agency will seek reimbursement * * *.

42 U.S.C. 1396a(a)(25) (emphasis added). This provision requires the state to consider the legal liability of a third party as a "resource" "available" to the applicant within the meaning of Section 1902(a)(17)(B); see also 42 C.F.R. 433.135(e)(1). It is difficult to understand how it supports respondent's assertion that Section 1902(a)(17)(D) only allows participating states to enforce generally applicable support statutes (or that the word "available," as used in Section 1902(a)(17)(B), means "contributed"). Section 1902(a)(25) of the Act, 42 U.S.C. 1396a(a)(25), was added in the 1967 Amendments to the Social Security Act (Section 229, Pub. L. No. 90-248, 81 Stat. 904). The purpose of paragraph (25) was not to allow the states to take into account the income of an applicant's spouse in making Medicaid eligibility determinations; Section 1902(a)(17)(D) had already accomplished that. The primary focus of Section 1902(a)(25), rather, was to require the states to make reasonable efforts to recover from unrelated third parties such as insurance companies or tort feasors.[3]

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[3]See, *e.g.*, H.R. Rep. No. 544, 90th Cong., 1st Sess. 123 (1967):

> *Payment for services by a third party.* It is obvious that many people need medical care because of an accident or illness for which someone else has fiscal liability; for example, a health insurer or a party who is determined by a court to have legal liability. In order to make certain that the State and the Federal Governments will receive proper reimbursement for medical assistance paid to any eligible person when such third-party liability exists, a new requirement would be included in title XIX. Under this provision, the State or local agency would have to take all reasonable measures to ascertain the legal liabilities of third parties to pay for covered services. Where the legal liability is known it would be treated as a resource of the recipient. In addition, if medical assistance is granted and legal liability of a

More important, Section 1902(a)(17)(B) and (D) of the Act, as interpreted by the Secretary, permit the states to consider the income of an applicant's spouse in determining Medicaid eligibility. Nothing in the Secretary's third party liability regulation cited by respondent (42 C.F.R. 433.135(e)(2)) purports *to require* participating states to ignore the income of the applicant's spouse in making Medicaid determinations and then file a lawsuit to recover money that it was never required to pay.

2. Respondent erroneously asserts (Resp. Br. 3-4, 16, 22, 29, 34-38, 81-82, 96) that the language of the 209(b) option makes the provisions of the SSI statute irrelevant to the issues in this case. According to respondent (Resp. Br. 34-35) "[t]he release from the SSI rules is established with these words: '. . . no State not eligible to participate in the State plan program established under subchapter XVI of this chapter [SSI]. . . .' " Like respondent's other statutory arguments, this one is difficult to square with the language upon which it is based. The SSI program is not a "State plan program"; it is administered by the federal government. Thus, the "State plan program established under subchapter XVI" referred to in 42 U.S.C. 1396a(f) is obviously not the SSI program.

As used in Title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*), the term "state" generally includes Guam, Puerto Rico, and the Virgin Islands. See 42 U.S.C. (Supp. III) 1301(a)(1). The "State plan program established under subchapter XVI" referred to in 42 U.S.C. 1396a(f) is the old combined categorical assistance program (42 U.S.C. (1970 ed.) 1381 *et seq.*) and not the SSI program. Since the old categorical assistance programs were not repealed in Guam,

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third party is established later, the State or local agency must seek reimbursement from such party. The Federal Government would receive its share of any reimbursement received.

See also S. Rep. No. 744, 90th Cong., 1st Sess. 184 (1967).

Puerto Rico, and the Virgin Islands (see Pub. L. No. 92-603, Title III, Section 303(a) and (b), 86 Stat. 1484), those jurisdictions are "states" eligible to participate in the "State plan program established under subchapter XVI." Thus, contrary to respondent's assertion, the words "no State not eligible to participate in the State plan program established under subchapter XVI of this chapter" (42 U.S.C. 1396a(f)) did not effect any "release from the SSI rules" (Resp. Br. 34-35). Rather, Congress simply made it clear that the 209(b) option was unavailable to Guam, Puerto Rico, and the Virgin Islands.[4]

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[4]Respondent correctly notes (Resp. Br. 89-90) that the Secretary's interpretation of the 209(b) spend-down provision results in the somewhat anomalous situation that a 209(b) state without a "medically needy" program may be required to cover an individual who would be ineligible in an SSI state without a "medically needy" program. With this arguable exception, however, the Secretary has always understood the relationship between the SSI statute and the Medicaid statute to prohibit 209(b) states from using Medicaid eligibility criteria for the categorically needy that are more liberal than those used in determining SSI eligibility. For example, the *Medical Assistance Manual* expressly states that:

> Eligibility conditions from the January 1972 medical assistance plan which are more liberal than those applied in the SSI program may not be retained for Medicaid coverage of the aged, blind and disabled as categorically needy * * *.

Medical Assistance Manual, Part 4, Subpart 4-20-20 (4), at 13 (1976); see also, *e.g.*, 39 Fed. Reg. 9512 (1974); 40 Fed. Reg. 60075 (1975); 42 Fed. Reg. 2687 (1977). As explained in our opening brief (at 36-44), the language of the 209(b) option, its legislative history, its purpose, and the relationship between the Medicaid and SSI statutes support the Secretary's conclusion that Medicaid eligibility criteria for the "categorically needy" in 209(b) states cannot be more liberal than those applicable under the SSI statute. Of course, 209(b) states, like SSI states, may choose to cover any of the optional groups provided for by Congress.

Respondent cites (Resp. Br. 87) Minnesota as an example of a 209(b) state that has Medicaid eligibility criteria more liberal than those of the SSI statute. We are informed that the Secretary has been engaged in discussions with Minnesota officials intended to secure voluntary compliance with the statute and the Secretary's regulations without the need for beginning formal proceedings under 42 U.S.C. 1396c.

Finally, like the court below (Pet. App. 8a), respondent contends (Resp. Br. 92-96) that it is inappropriate to require use of the SSI rules under the Medicaid program because the rules were intended to prevent fraud and are not related to "the policies behind availability or deeming" (Resp. Br. 94). This argument completely misconceives the nature of the analysis that led to the regulations. As set out more fully in our opening brief (at 27-49), the regulations are based upon the relationship between the two statutes and not the assumption that the reasons for adopting the rule in the SSI context are applicable in the Medicaid context. The reasons that prompted Congress to adopt the rules in the SSI context are essentially irrelevant. What is important is that *the income of an applicant's spouse is in fact considered (whether or not actually "contributed") in determining SSI eligibility.* The Medicaid statute does not prohibit the consideration of the income of an applicant's spouse (see our opening brief at 17-27). Hence, the Secretary's decision to require all participating states to consider such income if it would be considered in determining SSI eligibility is a reasonable construction of the statute and should be upheld.

3. Respondent accuses the Secretary of over-complicating this case. Although the issue presented does involve the interrelation between two complex statutory schemes, we agree that the essential question may be simply stated. When a Medicaid applicant or recipient is institutionalized, and his or her spouse has extra income sufficient to pay all or part of the applicant's medical expenses, who should pay those expenses: the spouse or the taxpayers? We submit that the answer provided by the Secretary's regulations is consistent with the Medicaid statute and reflects the intent of Congress.

For the foregoing reasons and the reasons stated in our opening brief, it is respectfully submitted that the judgment of the court of appeals should be reversed.

WADE H. MCCREE, JR.
Solicitor General

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